

Education Council (EC) Meeting Minutes

November 18, 2014

EC members present:	J Nixon	Guests:
L Anderson	D Patel	E Borman-Shoap
J Andrews	A Pereira	N Ercan-Fang
J Beattie	D Power	P Hobday
B Clarke	M Rosenberg	A Candy Heinlein
S Hansen	L Schimmenti	B Murray
R Holton	A Severson	R Westra
G Jacobs	S Slattery	EC members not attending:
W Jenson	Y Shimizu	K Brooks
A Johns	T Stillman	L Carson
S Katz	G Trachte	J Chipman
M Kim	S van den Hoogenhof	J Clinton
Z Lauer	M Wagar	R Cormier
R Michaels	K Watson	K Crossley
W Miller	J Weil	J Miller
	A Weiers	J Pacala
	M Woods	G Vercellotti
	B Yueh	

Minutes

Minutes for the October 21, 2014 EC meeting were approved with no corrections or additions.

Consent Agenda

AAMC Learning Environment Statement

Dr. Kathleen Watson reviewed the Learning Environment Statement recently received from AAMC and made Education Council members aware that the document will be placed on the Medical Education website. This language is to highlight the importance the quality of the learning environment plays in educating and developing quality physicians who provide quality patient care. There was no discussion; the Statement can be viewed at <https://www.aamc.org/initiatives/learningenvironment>.

Discussion

Today's meeting is to inform EC members of the status of the integrated longitudinal clerkships (LIC) being developed as clinical course rotations medical students can be considered for application and consideration. Our School has a long standing longitudinal clerkship with RPAP, which has been an active selection for medical students from our School for 43 years. There are two new LICs under development; Dr. Betsy Murray provided details for EPAC being developed here at the University under Pediatrics and Dr. Ercan-Fang talked about VALUE being developed at the VA. Zach Lauer, MS-4 serves on the EC Planning Committee and has put together questions from medical students in their efforts to understand how these might fit for their clinical rotations and future clinical practices.

Dr. Murray has been involved in the development of Education in Pediatrics Across the Continuum (EPAC) for approximately three years. The project was created by a group of national medical education leaders who are interested in exploring a couple of basic ideas.

These basic ideas include whether while learning in a longitudinal setting:

- 1) Is it possible for students to accurately self-identify an area of specialty interest early in their medical education and remain on that path for early specialty designation?
- 2) Is it possible to determine if the separation of UME and GME could be removed?
- 3) Is it possible the transition to GME could be based on competency/readiness for patient care at a highly responsible level rather than time based?

This is an innovation that is time variable and competency based advancement through the UME and the GME environments. Pediatrics is thought to be a discipline that was ready for this kind of project; existing science suggests that specialty selection for pediatrics for early in medical education training was likely to be retained until residency selection was completed. Similar data exists for; pediatrics was selected as the first target discipline for the first wave of these Pilot projects. Our School is participating with three other schools, UCLA-SF, Colorado, and Utah. All schools are creating education models based upon the above principles.

At our School the decision was made that LIC was the best curriculum delivery strategy for this project:

- it provides an opportunity to observe students longitudinally;
- in longitudinal interactions with patients,
- longitudinal access with the curriculum and longitudinal interactions with faculty.

The project team felt the environment was going to provide the best possible opportunity to watch the developmental advancement of these learners and make accurate entrustment decisions as we advanced their level of responsibility from an undergraduate to a graduate level. To accomplish this training a pediatric focused longitudinal integrated curriculum was developed that begins at the beginning of the third year of medical education. The LIC is meant to represent the core curriculum of medical school, its meant to represent all of the different disciplines and all are meant to be integrated with the exception of the Sub-I experience, will be part of the students' transition experience.

The basics of the LIC include:

- longitudinal continuity environments which the students will be assigned to
 - primarily outpatient clinical setting (same faculty that students are assigned to every other week)
 - weekly for pediatrics only they will be assigned to same continuity clinic for both undergraduate and graduate training
 - other disciplines will have a continuity experience assigned every other week for approximately a ½ day clinic
- Students will build a patient panel and they will track those patients through the various medical environments that those patients will need.
- Expectations are as follows:
 - to develop about a 50 panel patients sometime during the first few months of the LIC experience
 - their time will be flexible built into schedules to allow them to move with those patients into medical environments in order to create the most meaningful educational experiences.
 - Students will have protected time for independent study so they can develop their knowledge base in all of the disciplines.
 - On-line curricula such as MedU curriculum, with CLIP and FM cases will be available
 - also home-grown curricula for their use in building their knowledge base
 - students will complete required standardized knowledge assessments for the various disciplines
 - prep time will be required for Step 2
 - they will participate in weekly practice meetings

The pilot will include a set of four students that will be recruited to begin the LIC June 1, 2015. The hope is that the four students will function as a practice, meet with project faculty on a weekly basis. Topics of these discussions will include continuous quality improvement in their continuity clinic, puzzling or difficult cases, evidence based medicine, and various case discussions that are included the various curricula throughout the core clerkships and work through the small based curricular elements that are required.

Basically in using the LIC curriculum format they will meet all of the graduation requirements for completing medical school at the University of Minnesota. The progression along this curricula is designed to last a total of 52 weeks, but it is anticipated to time variable base upon competency based assessment and readiness for assuming greater and greater levels responsibility. Allow the students to be entrusted with those increasing levels of responsibility as they become prepared and ready for that entrustment. In order to facilitate the gradual progression to higher levels of responsibility the project leaders will implement a committee that functions in the same way as a "clinical competence" committee that is used at the GME level, they will meet quarterly to determine what the medical student's entrust-ability will be for the quarter. Once the Committee has determined that a student is entrustable at the level the required, the project team will begin transition

planning and the student will begin transition clinic. Steps will also include the Sub-Internship and an orientation to residency.

The bench marks that will be used to determine readiness for full entrustment at the graduate level are the Core Entrustable Professional Activities for Entering Residency (CAPER), which is a list of 13 professional activities developed by the AAMC to mark the expectation for an incoming intern beginning a residency for any discipline.

It is possible that a medical student could be ready to begin residency after year-3 when participating in EPAC. Flexibility will be used to determine readiness for residency, quarterly meetings will aid with benchmarks that will be transparent to students and will meet the School's requirements for graduation with the M.D. degree. Making time in the schedule for enrichment will be at the discretion of the student. For the first set (pilot) of 4 students, they will not be able to study abroad while they are enrolled in EPAC. They may be able to take short periods to do an elective, it is possible that their knowledge and ability will decrease during time away.

Informational sessions were provided for students; *EPAC Explore* was an intro and info session and *EPAC Focus* had very targeted activities. Students participated in a summer internship in Peds; participate in an FCT Year 2 group with pediatric content for the cases. There are approximately 10 who are being considered and the project team will use a methodology similar to the resident selection process. The first few iterations will be treated as the demonstration phase to create the best possible chance for success and will use a highly selective process in the beginning. Once the demonstration phase succeeds in illustrating that the project is possible, it may be possible to use a more liberal and potentially a threshold with random selection.

There is also value in working in this pilot project at a national level with access to the data and information being dealt with at the other schools involved in this pilot. An added value is having greater access to national LIC experts; this has involved learning from Dr. David Hirsh at Harvard who is one of the know LIC developers and locally learning from Dr. Kathy Brooks. We will probably be the first program in the country to have a pediatric focus in the LIC design.

The EPAC developers have dealt with the following questions:

- What methods will be used to determine when it is appropriate to successfully transition medical students to residency?
- Will the students have input with regard to making the decision to begin their graduate level medical education in their residency program?
- If individuals begin their residency at a different point than others, who do they consider as their peers?
- How will this affect their acculturation to residency, the feeling of fitting into a cohort of residents?

Those issues have been discussed at length at the national meeting of the medical schools participating in the pilot and one point that has total agreement across the membership is strength of the developmental trajectory that is being tracked allows for more candor and transparency because it isn't an "A, C, or a D". The continuum of assessment refers to the following:

- where the learner is at a given point on their developmental path
- a clear understanding where they began and where they need to be to complete residency
- assessing the student is much less a strict value judgment in terms of being good or bad or otherwise
- it offers opportunity to be more transparent about their progress
- student are included in discussions about where their progress is tracking

There is confidence with regard to the entrustment decisions when medical students and residents are being consistently evaluated. Readiness for entrustment at different levels of responsibility will fall to faculty decisions. Inexperienced medical trainees don't comprehend when they are able to move forward, medical experts involved in frequent evaluating have clearer ideas for what they are prepared to manage in performing patient care.

One of the goals of the pilot is to integrate these students deeply into the University of Minnesota Masonic Children's Hospital environment from the beginning of their LIC. It's possible they will already be enculturated with the pediatric residents. It isn't clear how students will self-identify in terms of their seniority and the residency hierarchy. There will be a very open dialog with students about their progress and

enrollment into the sub-internship to provide an opportunity for greater experiential opportunities while the program gets prepare a residency slot.

A practical question for the Education Council is in regard to graduation requirements of 76 credits in clinical experiences and work. The project is asking the medical school administration to innovate around a time variability and competency based advancement in a very transparent manner. It may be the actual time frame is less than currently required or it may require more time; but it will need to be variable. It's a very important question because the authority to have a variance in the graduation requirements does not lie within the Education Council but with the /Dean or the Faculty Assembly. The question must be posed to the next level of authority for making such changes. An added question with regard to the Sub-I, is whether four slots will be reserved for the pilot students. Dr. Briar Duffy feels with the capacity being created in Pediatrics they should be able to accommodate as many as all four students, should they all need to train at that level at the same time.

Veteran's Administration Longitudinal Undergraduate (Medical) Education (VALUE)

Dr. Recant-Fang, Director of VALUE, the LIC being developed at the VA hospital and clinic in Saint Paul provided details for the new program. VALUE and EPAC share very similar LIC goals. A specific focus for VALUE includes QI and patient safety and interprofessional education. The collaboration between the VA and the Medical School includes work with Drs. Rosenberg, Ercan-Fang, Watson, Pereira, and Brad Clarke (co-director) and along with a Steering Committee that has been involved in the development.

Initially an area of focus has been to find space for VALUE student participant and each will have an exam room to use for work with patients. In addition each student will be linked with a preceptor in every discipline. And every preceptor who works with one student will have a 10% dedicated time for teaching. The VA is strongly committed to partner with the University in developing and offering a LIC that can be successful.

An important goal for the VA is to have the LIC participants involved in continuous quality improvement with the patients and for students to be engaged with the panel of patients and to follow them across the continuum. A challenge for the VA was to establish a system so the students will be alerted to where in the system their patient is currently receiving treatment and this has been resolved.

VALUE focuses on transforming students from observers to participants in patient care. They will be incorporated into Patient Aligned Care Team (PACT), an interdisciplinary team, which will serve as their medical home. They will work in this interdisciplinary environment in that PACT and will have a sub-panel of patients within that PACT. This is the structure used for residents at the VA and the LIC with medical students is considered as genuinely important in teaching patient care.

The VALUE curriculum is based upon time required in each of the disciplines to achieve competence. An important component is having enough time to work with inpatients. The system will ensure student experience includes the required inpatient involvement; all patients from their patient panel will be assigned to the hospitalist teams.

Interprofessionalism

To ensure that students will have adequate interprofessional experiences the LIC has structured areas where this can be achieved. The PACT includes psychology students and interns, pharmacy students, nursing students, social work students, nutrition students and psychiatric residents. We do have an interprofessional student trainee cohort involved in the PACT and it would be very easy to incorporate medical students into that program

QI

QI is the secondary focus and it lends itself very well to interprofessional work. The VA's goal is to team-up VALUE students with other interprofessional trainees to do a QI project. The program will start with didactics in the form of a one-day workshop to learn the principles of QI, with a set of trainings called the Yellow-Belt classes. After the training, students will shadow their patients across clinics and strong mentoring will help identify some good QI projects. If they are unable to focus on any one project, there several on-going QI

projects to participate in to experience and contribute to that will be meaningful learning experience. Students will also do panel management through PACT which also includes a QI project.

Dr. Fang provided documentation for the Activity Tracking system, which include monitoring direct hours and indirect hours. Collecting this data will take place every week to two weeks, mechanisms for tracking the number of patients the admitted and their diagnoses. Currently this is being done through PxDx, which isn't popular and Brad Clarke is evaluating other programs.

Mentoring

The VA pledge to these student is that they are going to be mentored and as co-directors, Dr. Fang and Dr. Candy-Heinlein and Brad Clarke will mentor and if needed determine remediation for students. There will also be an evaluation committee that will function like a clinical competency committee that meets every month. Students' will be assessed with various tools and will receive formative feedback monthly.

Program Evaluations

At the end of the year the VA will do focus groups, interviews with students and surveys, to evaluate their experiences. They will also interviews and focus groups with preceptors to evaluate both sides of the experiences. They plan to do 360 evaluations in clinics and wards, patient satisfaction surveys and will attempt to get the administrators perspective. Dr. Fang feels strongly that patient outcomes would be valuable but at this time there isn't funding that is available to get that piece of information. In the future they will assess whether students feel this was a valuable experience after they enter residency and whether is a recruitment tool for physicians for the VA.

Questions:

- In terms of women's health approximately 25-30% of their panel of patients will be women and they will rotate to a very large clinic.
- The grading will be identical and in the first group to begin this program there will be ten students, which the VA's infrastructure can accommodate at this time. This will not displace students on any other required clerkships.
- Students will complete this LIC in May and will have completed internal medicine, primary care selective, neurology, surgery, surgical electives and psychiatry. They will be at the VA for 40 weeks, including vacations and they will get 36 credits (includes the QI experience).
- It appears the student pool will be those individuals who want to get the 36 credits at one experience. Another aspect of healthcare at the VA that attracts students which include teaching, the continuum with patients across disciplines, and the QI experience. Those selected will need to be self-motivated, self-directed and interested in the healthcare that the VA provides.

RPAP/MetroPAP

Dr. Watson noted that this was intended to be a progress report on EPAC and VALUE. Bringing information about RPAP and MetroPAP is to provide the distinctions of existing LICs so there is clarity about the difference as well as the similarities in the education experiences. For this reason this portion of the meeting isn't a reporting of the programs' standing.

Dr. Westra noted that RPAP has been in existence since 1971, approximately 43 years of educating students. The strength of RPAP is the connection of the student to a rural community and the 1:1 connection to a preceptor. The student has many experiences throughout the 9-month period they spend at the rural clinic. It is a 40 week program with 36 weeks of clinical experience. A strength of the program is when they are assigned to the preceptor, assigned to the hospital and assigned to the clinic they maintain that connection remains throughout the 9-month but they aren't actually with their rural family physician for the full 9 months. They do a family medicine clerkship, primary care selective, and an elective time with the primary care preceptor. But they are all doing surgery (a 6-week commitment) with all the same requirements and the shelf exam at the end. They also can do emergency medicine and/or a surgical sub-specialty. They potentially touch base back with their primary family physician preceptor by at least ½ day per week by potentially being in the clinic with that preceptor. This allows the students to follow patients that they have seen at past clinics and having that continued contact back.

The MetroPAP was started approximately 3 years ago and it operates exactly the same, only the students have a special interest in serving an underserved population in an urban community. So these sites are connected primarily to north Minneapolis and either the Broadway Family Medicine Clinic or the Central Avenue Clinic neighborhood and work out of North Memorial. The exact same requirements are fulfilled through this clerkship model. Both programs have been especially successful, there is a capacity of approximately 40 students in RPAP, there may a slightly more space but it has traditionally been capped at 40. MetroPAP is capped at about four at this time. UCAM is another variation as a clerkship, does satisfy 8 weeks of required clerkship with 4 weeks of elective credits.

Medical Questions regarding LIC participation

MS-4 Zach Lauer worked with representatives from each class to gather information from students across all 4 years with regard to the students' perspective on the programs within the MD degree and specifically the LIC offerings. These efforts also involved discussion by a larger group at the time of the Medical Student Council meeting.

1. How are these programs viewed by residency programs outside of Minnesota, especially by specialty programs that are not primary care specialties?

RPAP has been directly related to strong residency selection especially in family medicine. But the confidence that students exhibit after having the longitudinal experience seems to be what residency program directors focus on. RPAP has broad exposure across the Country and is well received. For students who are seeking residencies such as dermatology or orthopedics or any specialty that is research based with a required research project that must be completed should strongly consider whether they can complete that project and successfully add a longitudinal experience. Potentially consider what are the exact requirements of the residency that the student prefers to be selected for. RPAP for surgery, internal medicine, family medicine works well. For ophthalmology and urology students have been successful but it's difficult to get the sub-I experiences in the perfect timing that students want for their residency applications.

One of the statistics that is known is if a student is focusing on a surgery residency, their chances of being selected are much higher with an RPAP experience that they are without that background. They don't generally preclude you.

2. Students voiced concerns that taking a longitudinal clerkship for someone who is undecided, that they have "pigeon holed" themselves into one specialty and eliminating all of the others?

For the VALUE program students considering surgery will have surgical specialty opportunities in urology and ENT and orthopedics will be added. Within that during the 10 month period there is no reason why research would be precluded from the student's opportunities at the VA. QI research will also be an added possibility that can be focused on orthopedics during VALUE.

RPAP participants are both the clinic and the hospital and students are connected to the ER and surgery. They get to see so much it can help solidify their decision for family medicine or it can provide an understanding that they want to take a different path.

- longitudinal experience is something that stands out on a residency application
- Letters of recommendation from someone who has observed a student for a nine months can have impact
- The number of procedures that an individual may have the opportunity to complete over a 9-month longitudinal clerkship provides a high degree of excellence in experience going into residency.

There national director of residency programs surveys are very clear on what they want from applicants for orthopedics, urology, otolaryngology, dermatology and neurology; they want to see a letter of

recommendation from a peer in an academic institution. If students are intending to go into a career in surgical sub-specialties, this probably isn't the most ideal way to accomplish your goal.

3. Students asked how the timeline for longitudinal programs affects the opportunity to study for Step 1. This is especially concerning with regard to timing of required clerkships? Also how does the timing intersect with residency application and sub-specialty experience for residency applications?

It does require very careful planning for a student who has determined that they will be applying for those highly competitive residency programs. With regard to study for Step 1, there will be changes in the timing of required clerkship with a push to have year-3 students beginning these clerkships in Period 1.

4. Various questions about grading and shelf exams, with the LIC programs and Honors?
Will they have more or less ability to do well on the exams?
-Data shows that shelf exam results are very similar. National data and international data for ---LICs shows results as consistent.
5. Is it true that the LIC experience is automatically a good decision for everyone in medical school at the U of MN?

Action points:

Suggestions from Students to Medical Education

There is a gap between what has been provided at the Council meeting and what the students understand to be correct. Do a comparison for 2nd year students that reflects what the numbers show; grading, compare students in LICs with those in the main stream, how do they do

Students need to understand LICs aren't a one size fits all, it is something to be considered and students making the decision for their individual interest level should get the details. Those who question the LIC value should understand through the comparison if it has value for them personally.

Announcement

Dr. Rosenberg noted that Dr. Wes Miller will be retiring and his last meeting will take place on December 16th. The selection of the new chair of the Council is made by the Dean, he has chosen Dr. Brad Benson to be the new chair, Dr. Benson as accepted the invitation. He invited everyone to attend the next meeting to celebrate Dr. Miller's service.

December 16, 2014 meeting cancelled

**Next Meeting, January 20, 2014
4-5:30 B646 Mayo**